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Notice of Independent Review Decision

January 12, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left knee medial unicompartmental knee Arthroplasty with 1 inpatient day.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This reviewer is a Board Certified Orthopedic Surgeon with over 42 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who experienced an injury to his knee on xx/xx/xx.

04/23/2014: MRI Left Knee. **Impression:** 1. Partial medial meniscectomy with tears of the body and posterior horn. 2. Mild to moderate medial compartment tibiofemoral joint articular cartilage loss.

04/25/2014: Follow-Up Evaluation. **Subjective:** Patient presents to the clinic for left knee pain. Patient states that overall the symptoms have increased. ROM has decreased patient reports a feeling pressure or fullness that he has to push through to move knee. Patient's gait has returned to normal. Pain level has increased. Patient reports a pain level of (Visual Analog Scale) Popping persists. Other reported complaints: Patient with pain posterior to patella that is worsening. **Current Medications:** Diabetes Med **Allergies:** Naprosyn **Past Medical History:** Diabetes Mellitus (+) Hypertension (-), Peptic Ulcer (-), Thyroid Disease (-), Liver/Kidney Disease (-). **Physical Exam:** Alert and oriented to time, place, and

person. No apparent distress. Antalgic gait. NI gait. Gait has been affected. Knee: Left: Inspection well healed surgical scars. ROM flexion remained the same. Extension remained the same. Tenderness reported remained the same patellar pressure or manipulation is very painful. Strength is remained the same. Effusion remained the same. Medial collateral ligament normal. Lateral collateral ligament normal. Mcmurray test positive lateral meniscus. Lachman test negative. Drawer test negative. **X-rays:** Knee 2 views (ap, lat) were negative for fracture or dislocation. Special Testing/Specialist Results: 9/10/2013-MRI on knee Left without contrast 1) Truncation of the midbody portion of the medial meniscus with suspected oblique to possibly slightly complex tear of the posterior horn portion of the medial meniscus 2) Partial medial meniscectomy with tears of the body and posterior horn. 3) Mild to moderate medial compartment tibiofemoral joint articular cartilage loss. 9/24/13-Orthopedic surgeon: Left Knee -1. 9/19/13: Patient indicates surgery planned 10/15/13 and will resume PT after surgery; surgery performed 10/15/13, follow up 10/22/13 start PT, follow up 11/12/13: Pt is to continue PT at this time, follow up 12/12/13: cortisone injection given, follow up in mid January; Pt indicates told needs another MRI for further eval pending approval, f/u after MRI. Will obtain notes. 2/11/14: Surgery scheduled for 2/25/14. 2/25/14: Knee surgery. 3/04/14: start therapy. **Recommendations:** 1. No PT at this time. 2. Medications: Lodine 400mg #14, Flexeril 10 mg #14, Ultracet 37.5/325 mg #60 3. Pt being recommended for referral to ortho for second opinion 4. Pt was advised to follow up with his primary care doctor for high heart rate

05/02/2014: Office Visit. **HPI:** This is a male who presents for knee evaluation. Pt here for 2nd opinion left knee. He states he has had 2 surgeries. He states still has popping and pain. Pt had injured on the job and was diagnosed with medial meniscal tear. The pt has had 2 arthroscopies and continues to have pain on the medial aspect of the knee and had a repeat MRI of the knee which I reviewed in April 23, 2014. This showed evidence of medial meniscal tear and showed mild to moderate medial compartment chondromalacia. The last surgery was done on 2/25/14 at that time he was found to have some fraying and tear of the medial meniscus and had a partial meniscectomy. No mention was made of any chondromalacia at that time. The patient has not been able to go back to work because of continued pain. He's had a steroid injection which he said it did not help much and he been through therapy. **Physical Exam:** Left Knee: Antalgic gait. Pt has well-healed incision on the left. Right knee has full ROM without significant pain or tenderness and no significant crepitation and ligament exam is normal. Left knee is tender along the medial aspect is almost full motion and normal ligamentous exam without effusion. Mild positive McMurray's. Minimal crepitation. **Impression and Recommendations:** Medial meniscus tear, Assessment-new. **Orders:** Pt is status post 2 medial meniscectomies. Oftentimes a repeat MRI would show signal change within the cyst meniscus after arthroscopy and the surgeon using a vapor wand which will probably cause some signal abnormality in the medial meniscus. It is doubtful another arthroscopy is going to help him significantly.

05/08/2014: Office Visit. **HPI:** I saw pt in the office today for a follow-up evaluation. He is following up on his left knee injury. He states he felt a pop in his

knee while doing squats in therapy a few weeks ago. He has continued pain and numbness down his leg. **Exam:** Ht: 72 in. Wt: 200 lbs BMI: 27.22 (overweight) P: 91 BP: 120/81 Incision: Well healed. There is no tenderness in the knee, medial joint line. Positive tinel over fibular head. **ROM:** Active Flexion: 100 degrees Active Extension: 0 degrees. Apley Compression: Positive **Diagnostic Interpretation:** Diagnostic Test: MRI Findings: suggestion of horizontal tear medial meniscus, chondromalacia **Assessment:** Pt is having persistent symptoms. His recent repeat MRI findings are interesting since in the last surgery I spent extra time to make his meniscectomy was complete using a shave and an ablator. He also continues to have paresthesias in the peroneal nerve distribution. **Plan:** Recommend EMG/NCS left lower leg.

05/30/2014: Electromyography Report. **Assessment:** The nerve conduction studies are normal. The needle exam is also normal. **Conclusion:** This is a normal EMG study. The patient notes that subsequent to the squatting in pt. He has developed episodic, transient numbness in his left lower extremity. The numbness and tingling usually begin after he feels a pop in his left knee. The distribution of the sensory abnormality is on the lateral aspect of the left leg ranging from the knee to the middle of his foot encompassing the entire left half of his leg. Generally speaking, after the pop it takes approximately 10 minutes for the numbness to evolve and encompass the entire distribution. He also notes, not infrequently, that this numbness also goes about halfway up this thigh, again encompassing the lateral half of his leg. He denies any weakness associated with this numbness and tingling which does come and go. He notes that after the onset it may last up to several days and then it will be gone and he will be without symptomatology. A clinical examination reveals the decreased sensation in the distribution noted. Motor exam is normal for tone, bulk and power and deep tendon reflexes are 2/2 at the knee and the ankle with flexor plantar responses. Addendum: The transient area of numbness in the left lower extremity is not suggestive of any peripheral nerve abnormality. Certainly, an abnormality within the knee would not be expected to cause a sensory loss proximal to the knee. I cannot absolutely rule out the possibility of a lumbosacral radiculopathy but with a normal motor exam, normal deep tendon reflexes, lack of low back or hip pain and the intermittent nature of the symptoms, this would seem to be an untenable diagnosis.

07/03/2014: Functional Capacity Evaluation. **Assessment:** Strength: 1. Sensation grossly intact. 2. 5/5 bilateral upper extremity strength. 3. Good balance. 4. Able to crawl 5. Able to climb 6. Able to push/pull 7. Able to perform prolonged overhead reaching. Weaknesses: 1. Subjective complaints of pain. 2. Left knee edema 3. Decreased left lower extremity ROM 4. Decreased bilateral lower extremity strength 5. Decreased ability to bend, squat, lift carry. 6. Poor cardiovascular endurance. **Recommendations:** Mr. is unable to perform the essential functions of his job. He is unable to perform the material handling component to include lifting and carrying of 100+ pounds. He was only able to demonstrate a lift and carry up to 45 pounds. He is able to perform the non-material handling component to include crawling, kneeling, climbing, pushing, pulling and prolonged overhead reaching; however, he reports increased pain with

all non-material handling components. It is therefore recommended that Mr. continue to perform the home exercise program as learned in previous therapy and follow up with his physician as directed.

08/20/2014: Follow Up Evaluation. **Subjective:** Pt here for f/u and pain level is 6/10. The pt is having persistent pain and decreased ROM. Overall symptoms have remained the same. Pain level has remained the same. Pt reports a pain level of (VAS) 6. Swelling has remained the same. Stability has remained the same. Popping persists. **Exam:** ROM flexion remained the same. Extension remained the same. Tenderness reported remained the same tender to palpation on the medial and lateral aspect of the infrapatellar fold. Strength is decreased. Effusion remained the same. Mcmurray test positive medial meniscus and lateral meniscus. Lachman test negative. Drawer test negative. **Recommendation:** 1. No physical therapy at this time. 2. Medication: Mobic 15mg #7, Ultracet 37.5/325mg #60 3. Patient, employer and insurance has had meeting and decided that patient should progress to knee replacement if possible. I will place consult today for possible knee replacement. 4. Continue home exercises and ice to the affected area. 5. Referral to the Ortho for Left Knee.

08/25/2014: UR. **Rationale for Denial:** The patient is a male who reported an injury on xx/xx/xx. The patient was seen most recently on 8/20/14 whereupon it was stated that the patient had injured his left knee while walking up stairs and heard a pop with immediate pain in his left knee. The patient had undergone a previous left knee ligament repair surgery in 2000 but had no problems prior to his work injury. The patient had been off work since this injury. It reported that the patient had undergone plain view x-rays and 3 MRI's of his left knee. He also underwent left knee arthroscopy in 10/2013 and sustained a re-tear in physical therapy and underwent a second left knee arthroscopy in 02/2014. After the second surgery, the patient again reinjured his left knee during therapy and underwent 2 injections which did not help, with his last given in 4/2014. No further studies or medical treatment had been rendered with the patient having positive pain with rest and nighttime pain. It further indicated that he has pain with prolonged walking, standing, and twisting activities but no swelling was indicated. He reported mild catching, locking, popping, and feelings of instability. He has utilized pain medications and compound cream as needed for pain. The physician is now requesting left knee medial unicompartmental knee Arthroplasty with 1 inpatient day CPT 27446. According to ODG, with a BMI of 37.3 the patient does not meet the Guideline criteria for undergoing the requested unicompartmental knee Arthroplasty. On examination, although it was indicated the patient had an antalgic gait with an abnormal short stepped test and an abnormal stiff leg test, a thorough review of the patient's knee was not provided for review to indicate the patient's functional deficits as well as an overall review of the patient's affected area. I discussed the case who indicated he would fax additional clinical information. I received additional clinical dated 8/22/14 at 12:05PM CST to include a MRI (dated 4/23/14) that indicated that he had a complex tear of the posterior horn of the medial meniscus with mild to moderate articular cartilage loss scattered along the weight bearing portion of the medial compartment of the tibiofemoral joint. Otherwise the tibiofemoral and patellofemoral articular cartilage

was grossly intact. After review of the documentation, the requested surgical procedure cannot be supported without a more through rationale for the patient undergoing a unilateral Arthroplasty at this time. Subsequently, the inpatient stay of 1 day is not considered medically necessary at that time and is non-certified.

11/25/2014: Examination. **HPI:** Mr. is a male (height: 6'0", weight: 258 lbs.) with left knee medial meniscus tear and medial compartment arthrosis. His BMI today is 35.0. The patient complains of the following symptoms(s) and severity on a scale of 1-10: Left knee pain (6). The patient has a previous symptom located ot the left knee requiring surgery ligament repair 2000. He is currently off work. Previous studies obtained include X-Ray, MRI. Previous treatment and their effect are: external immobilieation helps the symptoms, oral medications helps the symptoms, therapy has no effect on the symptoms, injection helps the symptoms, surgery helps the symptoms. **Examination:** Knee ROM: Extention:0 Flexion:100 Right: Normal: Left: Quadricepts: 4 Hamstring: 5 Gastrocnemius: 5 **Conclusion:** Diagnosis: Left: Osteoarthrosis, localized, primary 715.16 Meniscus Tear Medial 836.0 **Plan:** Schedule surgery: Left medial Unicompartmental Knee Arthroplasty 27446. Pain medication PRN, recommend restricted duty until surgery and then off work, RTC for PO visit, sooner if he is having any problems.

12/03/2014: UR. **Rationale for Denial:** According to the ODG, although it was noted the patient had undergone previous conservative modalities to include physical therapy and injections, his ROM was not listed as less than 90 degrees, there was no mention of any nighttime joint pain, and no mention of lack of pain relief with conservative care. His documentation stated that he had relief with oral medications, injections, and his previous surgery. Additionally, he has a body mass index of less than 40, there were no imaging studies provided for review to verify the patient necessitates undergoing a left medial unicompartmental knee Arthroplasty. Peer to peer contact was not successful. As such, the requested surgery is not supported and is non-certified. Regarding the 3 day inpatient stay after undergoing a knee replacement, with the patient not meeting the primary surgical procedure criteria, the subsequent request for 3 day inpatient stay is not medically necessary and is non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse determinations are upheld. There is no description in this patient's records of only one compartment involvement. His MRI only notes mild to moderate medial joint cartilage involvement, and there is no surgical description of uni-compartment involvement. Per ODG he would not be considered a candidate for a uni-compartment knee replacement. Therefore, the request for left knee medial unicompartmental knee arthroplasty with 1 inpatient day is not found to be medically necessary.

Per ODG:

ODG Indications for Surgery™ -- Knee arthroplasty:

Criteria for knee joint replacement (If only 1 compartment is affected, a unicompartmental or partial replacement may be considered. If 2 of the 3 compartments are affected, a total joint replacement is indicated.):
1. Conservative Care: Exercise therapy (supervised PT and/or home rehab exercises). AND Medications. (unless contraindicated: NSAIDs OR Visco supplementation injections OR Steroid injection). PLUS
2. Subjective Clinical Findings: Limited range of motion (<90° for TKR). AND Nighttime joint pain. AND No pain relief with conservative care (as above) AND Documentation of current functional limitations demonstrating necessity of intervention. PLUS
3. Objective Clinical Findings: Over 50 years of age AND Body Mass Index of less than 40, where increased BMI poses elevated risks for post-op complications. PLUS
4. Imaging Clinical Findings: Osteoarthritis on: Standing x-ray (documenting significant loss of chondral clear space in at least one of the three compartments, with varus or valgus deformity an indication with additional strength). OR Previous arthroscopy (documenting advanced chondral erosion or exposed bone, especially if bipolar chondral defects are noted). (Washington, 2003) (Sheng, 2004) (Saleh, 2002) (Callahan, 1995)
For average hospital LOS if criteria are met, see Hospital length of stay (LOS). See also Skilled nursing facility LOS (SNF)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**